HIPAA AGREEMENT

SECTION 1

I, ________________________________, give the practice of David A. Gentile, DO, CAC, PC. permission to leave medical information at the following: (see below)

A. Home Answering Machine: ___________________________
B. Cell Voicemail: ___________________________
C. Office Voicemail: ___________________________

Family member(s) or designated representative(s): Please print and list full name and relationship.

Name: ___________________________ Phone: ___________________________
Name: ___________________________ Phone: ___________________________
Law Office of: ___________________________ Phone: ___________________________

Please check all information that can be left on the above answering machine(s) or with the above representative(s):

______ Test Results
______ Lab results
______ Confirming appointments
______ Medication changes
______ Billing/insurance inquiries
______ Any information pertaining to all aspects of my medical care (includes all of the above).

Signature ___________________________________________ Date ______________________

Relationship to patient (if minor, or signed by personal representative(s)): ______________________

SECTION II

I, ________________________________, do not want my information pertaining to all aspects of medical care left on my answering machine or with anyone other than myself.

I understand that I may revoke/amend this authorization at any time as long as it is in writing.

Signature ___________________________________________ Date: ______________________